

EXHIBIT A

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury 10/01/2007	3. Employee Name (Last, First, MI) SINGLETON, CHRISTINE J.		
4. Employee Address (Street No. and Name) 940 HARRISON		5. City LINCOLN PARK	6. State MI	7. Zip Code 48146
8. Employer Name United Parcel Services				9. Federal ID No. 36-2407381
10. Employer Street Address 25600 NORTHLINE ROAD		11. City TAYLOR	12. State MI	13. Zip Code WAYNE
14. Carrier or Self-Insured Name Liberty Mutual Insurance			15. NAIC or Self-Insured No. 23043-111	16. Zip Code 46207
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No. 471-694863		21. County of Injury WAYNE		22. County Code (if known)

23. Reason For Dispute

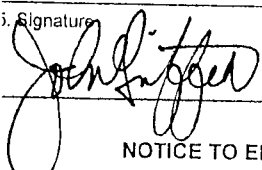
- A. ☐ Injury not work related
 B. ☐ Medical treatment not related to injury
 C. ☐ Further investigation required (please specify below)
 D. ☐ Additional information required from employee (please specify below)
 E. ☐ Vocational rehabilitation dispute only (please specify below)
 F. ☒ Other (please specify below)

PER THE INDEPENDENT MEDICAL EXAM OF DR. PAUL DROUILLARD DATED 12/28/07 THE EMPLOYEE IS CAPABLE OF RETURN TO WORK WITH NO RESTRICTIONS AT UPS. THEREFORE, BENEFITS HAVE BEEN TERMINATED.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, R408.33(1)
 Completion: Mandatory
 Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print) John Griffith	25. Signature 	26. Telephone No. (800) 752-5832	27. Date 01/09/2008
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NOTICE TO EMPLOYEE

By filing this form, your employer or its workers' compensation insurance company has indicated to the Bureau of Workers' Disability Compensation that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

If you feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may request an informal conference or file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Bureau of Workers' Disability Compensation at one of the offices listed below.

DETROIT
State of Michigan Plaza Building
1200 Sixth Street, 12th Floor
313) 258-2770

FLINT
Bristol West Center
G-1388 West Bristol Road
(810) 760-2819

KALAMAZOO
4203 West Main
(616) 337-3630

PONTIAC
NBD Building
28 N. Saginaw, Suite 1310
(810) 334-2497

ESCANABA
State Office Building
105 Ludington
906) 786-2081

GRAND RAPIDS
2942 Fuller Street N.E.
(616) 447-2671

LANSING AREA
2501 Woodlake Circle,
Okemos
(517) 241-9393

SAGINAW
State Office Building
411-K East Genesee
(517) 758-1768

MOUNT CLEMENS
10th Floor, Old Country Building
10 N. Main
(810) 463-6577

TDD in Lansing
(517) 322-5987

NOTICE OF DISPUTE

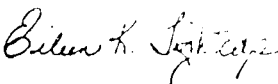
Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury 02/09/2006	3. Employee Name (Last, First, MI) Conforto, Janet M		
4. Employee Address (Street No. and Name) 14735 Park		5. City Livonia	6. State MI	7. Zip Code 48154
8. Employer Name United Parcel Service				9. Federal ID No. 36-2407381
10. Employer Street Address 29855 Schoolcraft Rd		11. City Livonia	12. State MI	13. Zip Code 48150
14. Carrier or Self-Insured Name Liberty Mutual Insurance Company			15. NAIC or Self-Insured No. 230430111	16. Zip Code 46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No. WC 471-633980		21. County of Injury		22. County Code (if known)
23. Reason For Dispute A. _____ Injury not work related B. _____ Medical treatment not related to injury C. _____ Further investigation required (please specify below) D. _____ Additional information required from employee (please specify below) E. _____ Vocational rehabilitation dispute only (please specify below) F. <input checked="" type="checkbox"/> Other (please specify below) Cutting off wage loss benefits only. Per our ME, she is full duty (09-11-06)				

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Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print) Eileen K Lightcap	25. Signature 	26. Telephone No. (800) 752-5832	27. Date 09/11/2006
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RECEIVED

SEP 18 2006

NOTICE OF DISPUTE

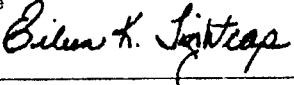
Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury 11/01/2005	3. Employee Name (Last, First, MI) Didonato, Daniel P		
4. Employee Address (Street No. and Name) 18267 Mac Arthur		5. City Redford	6. State MI	7. Zip Code 48240
8. Employer Name United Parcel Service				9. Federal ID No. 36-2407381
10. Employer Street Address 29855 Schoolcraft Rd		11. City Livonia	12. State MI	13. Zip Code 48150
14. Carrier or Self-Insured Name Liberty Mutual Insurance Company			15. NAIC or Self-Insured No. 230430111	16. Zip Code 46032
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No. WC 471-634931		21. County of Injury		22. County Code (if known)
23. Reason For Dispute				
A. <input checked="" type="checkbox"/> Injury not work related B. <input type="checkbox"/> Medical treatment not related to injury C. <input type="checkbox"/> Further investigation required (please specify below) D. <input type="checkbox"/> Additional information required from employee (please specify below) E. <input type="checkbox"/> Vocational rehabilitation dispute only (please specify below) F. <input type="checkbox"/> Other (please specify below)				

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Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

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24. Preparer Name (Please print) Eileen K Lightcap	25. Signature 	26. Telephone No. (800) 752-5832	27. Date 03/30/2006
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NOTICE OF DISPUTE

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Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No. 3-11-2446	2. Date of Injury 06/16/2005	3. Employee Name (Last, First, MI) MILLER, JOHN E.		
4. Employee Address (Street No. and Name) 10555 N COUNTY LINE HWY		5. City MILAN	6. State MI	7. Zip Code 48160
8. Employer Name United Parcel Services				9. Federal ID No. 36-2407381
10. Employer Street Address 540 SOUTH MANSFIELD ST.		11. City YPSILANTI	12. State MI	13. Zip Code 48197
14. Carrier or Self-Insured Name Liberty Mutual Insurance			15. NAIC or Self-Insured No. 23043-111	16. Zip Code 46207
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	16. Zip Code
20. Claim or File No. 471-609205		21. County of Injury WASHTENAW		22. County Code (if known)

23. Reason For Dispute

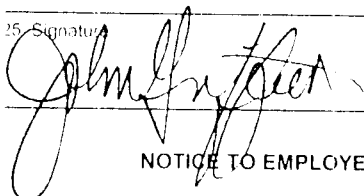
- A. ☐ Injury not work related
 B. ☐ Medical treatment not related to injury
 C. ☐ Further investigation required (please specify below)
 D. ☐ Additional information required from employee (please specify below)
 E. ☐ Vocational rehabilitation dispute only (please specify below)
 F. ☒ Other (please specify below)

PER THE IME OF DR. DROUILLARD THE EMPLOYEE IS NO LONGER DISABLED FROM HIS JOB AT UPS AND MAY RETURN TO UNRESTRICTED DUTY. THEREFORE, BENEFITS HAVE BEEN SUSPENDED BASED ON THIS EXAMINATION.

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 Completion: Mandatory
 Penalty: Workers' Disability Compensation Act, 418.631; 418.631; R408.33

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24. Preparer Name (Please print) John Griffith	25. Signature 	26. Telephone No. (800) 752-5832	27. Date 10/19/2005
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